EC-2

rev July 2009

Hawaii Employer-Union Health Benefits Trust Fund

ENROLLMENT FORM FOR RETIREES

Customer Service: Oahu (808) 586-7390
Toll Free: 1 (800) 295-0089

1. Event:

2. Event Date:(MM/DD/YY)

See Instructions on reverse side BEFORE completing this form. Refer to your benefits guide or our website for plan details.

3a. Employee's Last Name, First Name, M.I.			3b. Social Security Number (**for new enrollees only**) or EUTF ID Number:
3c. Mailing Address (☐ Check this box if your address has changed):			4. If your spouse or domestic partner is a State or County Employee or Retiree, please provide their SSN or EUTF ID:
3d. City:	3e. State:	3f. Zip Code:	***If you are including your spouse or domestic partner in your health benefit plans, please complete sections 5 - 9.***

3g. Marital Status: ☐ Married ☐ Single	3h. Gender: ☐ Male ☐ Female	3i. Birth Date: (MM/DD/YY) / /	3j. Home Phone Number:	3k. Cell Phone Number

5a. Add	5b. Delete	6a. Dependents: First Name, M.I., Last Name (if different)	6b. Birth Date (MM/DD/YY)	6c. SSN or EUTF ID Number	7. Relationship	8. Gender: Check box as appropriate
☐	☐		/ /			☐ Male ☐ Female
☐	☐		/ /			☐ Male ☐ Female
☐	☐		/ /			☐ Male ☐ Female

9. **Plan Selections, Changes or Cancellations** - Make your selection by checking the box for the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan Section	Carrier Selection	Self	2-Party	Family	Waive/cancel
Medical Plan (Only one selection is allowed from this list)	EUTF PPO Medical (**HMA** Network)	☐	☐	☐	☐
	EUTF PPO Medical (**HMSA** Network)	☐	☐	☐	
	Kaiser Comprehensive (HMO Medical and Drug)	☐	☐	☐	
Prescription Drug (Not a valid selection with Kaiser HMO)	Informed Rx Prescription Drug	☐	☐	☐	☐
Dental Plan	Hawaii Dental Service - Dental	☐	☐	☐	☐
Vision Plan	Vision Service Plan - Vision	☐	☐	☐	☐
Life Insurance Plan	Standard Life Insurance - Life				☐

10. If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read item 10 on the back of this form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

11. Retiree Certification (see instructions on the back of this form)

Retiree Signature:_____ Date:

12. **Medicare PART B enrollment:** Chapter 87A-23(4), HRS requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, and have not already done so, please submit a copy of the Medicare card and complete this section to initiate quarterly reimbursement.

Name of enrollee:

Medicare Claim #: (ID number listed on the blue and red Medicare Card)

Please submit your signed and completed form via mail or hand delivery to:
EUTF, P.O. Box 2121, Honolulu, Hawaii 96805-2121 or you may fax it to 808-586-2161.

INSTRUCTIONS FOR COMPLETING EC-2 FORM

A. Print or type clearly. If this form is unreadable, it may be sent back to you without action.

B. Please submit form to the EUTF by mail, fax, or hand delivery.

C. This form is effective for changes made on or after **July 1, 2009** and may be updated periodically.

D. Section:

1. Event -Please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Address Change, Marital Status Change, Death, Change in Student Status, Add Dependent, Cancel etc. If there are simultaneous events, please describe the most important event. For example, if the event is a Birth, enter Birth in the event section.
2. Event Date - Please enter the date the event took place.
3. Enter Retiree's information. For 3b, enter the EUTF ID #. If you are enrolling for the first time, you must enter your social security number.
4. Enter EUTF ID # of Spouse or Domestic Partner if your spouse of Domestic Partner is a State or County Employee or Retiree. Be sure to complete sections 5 - 9, if you want to cover your spouse or domestic partner.
5. Check “Add” box to add dependent, check “Delete” box to delete dependent.
6. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter their birth date and social security number. Otherwise, you may leave items 6b and 6c blank. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write "Continued" on the last line of the Dependent section. Use a separate sheet of letter size paper to list additional dependent(s) information.
7. Use the following codes for Relationship column:

   SP = Spouse CH = Child DC = Disabled Child$^{\surd\surd}$

   DP = Domestic Partner$^{\surd}$ DPC = Domestic Partner Child$^{\surd}$

   For Relationship codes with $^{\surd}$ or $^{\surd\surd}$, please see item below for further instructions.

   If you are adding a disabled child, domestic partner and child or an adopted child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at www.eutf.hawaii.gov for more information.
8. Gender – check the appropriate box; either Male or Female.
9. Plan Selections. Only one plan from the Medical plans and the appropriate coverage for you may be selected. If you choose a PPO medical plan, you now have the option to select or not to select informedRx if you also want prescription drug coverage. If you do not want any plan coverage, mark the "Cancel/Waive" box. Life Insurance is provided for the retiree only.
10. **IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your Retiree Open Enrollment Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.**
11. Certification: Signature of Retiree certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature.
12. **IMPORTANT NOTICE: When you or your spouse or domestic partner become eligible for Medicare Part B, you or your spouse or domestic partner must enroll in Medicare Part B and forward a proof of enrollment to the EUTF. Failure to comply may result in loss of all health benefits coverage.** If you or your dependents have recently enrolled with Medicare Part B, please complete this section and submit this EC-2 form and a copy of your Medicare card or the letter notifying you of your enrollment in Medicare Part B to the EUTF.

NOTE: